Religiosity in Drug Use and Addiction Among African American Women: A Qualitative Phenomenological Study

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Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

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Approved by:

Dr. Stacey Lilley, Committee Chair

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Abstract

The purpose of this qualitative phenomenological study was to understand the influence of religiosity on experiences in Celebrate Recovery (CR) groups for African American (AA) women in Central Georgia. AAs die from drug overdoses at rates that exceed all other racial groups in the United States. Although many treatment options exist, they remain largely ineffective at helping people addicted to drugs sustain sobriety. Religiosity has been shown to influence quality addiction treatment access. The theory that guided this study was Parsons's classic structural-functional analysis of religious organization theory because it describes religion as an integrated system of beliefs or practices related to sacred aspects or things responsible for uniting one moral community to which all other things adhere. Semistructured interviews were conducted to collect data from 13 participants. A thematic analysis process was used to analyze the data and, ultimately, identify themes among the data.

Keywords: religiosity, Celebrate Recovery, substance abuse, African American women

Dedication

I dedicate this study to my kids Jabir Saleem, Yasir Saleem, Shakirah Saleem, Khadijah Saleem, Nazirah Saleem, and Jacob Saleem. To my husband of 21 years, Rasool Saleem, thank you for being one of my biggest supporters during this journey. Also, I would like to thank my mother, Gloriasteen Mercer, for all her words of encouragement on a daily basis, especially the days I wanted to give up. My father, Walter Axom, Sr. and Mrs. Deborah Axom for your daily words of encouragement and prayers. I dedicate this study to the rest of my family: Aunt Elestine Driskell, Uncle Willie Driskell, and Aunt Beatrice Wilson. I am forever grateful to family and friends for your unconditional love and support. Finally, to my late Daddy, “Charlie Mercer” I surely miss you, and I know you are in heaven smiling down on me. This has been a life-changing experience and I am forever grateful and blessed.

Acknowledgments

Giving honor to God from whom is the head of my life without him this would not have been possible. This degree is not just for me, but for my previous family generations grandmothers and grandfathers with an elementary school educations thanks for paving the way for me to have this opportunity. Also, I wanted to thank my committee chair, Dr. Stacey Lilly, for giving me guidance, having patience, and understanding during this process. Thank you, Dr. Holly Johnson committee chair member, for giving me feedback, positive constructive criticism, and being a listening ear to me vent. I would like to thank two special ladies, Dr. Kenya Miller and Dr. Toni Woodlon, for your words of encouragement, prayer sessions, and being great friends and mentors. Lastly, I would like to thank everyone for their love and support over the last two years. This was not a painless process, but it was well worth the journey! May God continue to use me for his glory!

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African American (AA)

Celebrate Recovery (CR)

Chapter One: Introduction

Overview

According to a report released by Substance Abuse and Mental Health Services Administration (2020), the rate of death from drug overdoses was almost twice as high for African Americans (AA) than for the overall United States population. During the COVID-19 pandemic, that rate increased and produced a wider gap in overdose death rates between AAs and Whites (Friedman et al., 2022). Drug and substance abuse is particularly prevalent among AA women (Dada et al., 2018).

Researchers such as Seifer (2018) and Yeager et al. (2018) argued the intervention implementations and treatments for individuals suffering from drug abuse were ineffective. Over the recent years, religiosity has been demonstrated to have an impact on drug use and addiction behaviors (Abdeslam, 2020; Beraldo et al., 2019; Lund, 2017; Monacis et al., 2017; Petet, 2019; Prosek et al., 2017; Yeterian et al., 2018). The focus of this study is the lived experiences and perceptions of AA women who have experienced religious substance abuse treatment.

In Chapter 1, I will introduce the study by providing pertinent data to help contextualize the central phenomenon. Specifically, background information, including details about setting and existing research related to the study, will be discussed in Chapter 1. Additionally, the problem will be explained, as well as the significance of the study, and the research questions that will guide the study. Lastly, the key terms and definitions that will help readers comprehend this study will also be listed and explained.

Background

Dada et al. (2018) found young AA women were almost 18 times more likely than other women to report substance abuse. Dada et al. also provided evidence women treated for heroin

were significantly more likely to be White and younger than 25 years old. Researchers have frequently cited ineffective interventions implementations and treatments for individuals abusing drugs (Pinedo et al., 2020; Seifer, 2018; Yeager et al., 2018). Yeager et al. (2018) investigated traditional preventative school-based interventions and alternative approaches to interventions for middle adolescents. Seifer (2018) argued although treatment options and access to medication for young people were being addressed by the government, searching for options to augment policy efforts would be necessary. Pinedo et al. (2020) explored barriers to specialty substance abuse treatment programs among women with recent substance use disorders by race/ethnicity and found attitudinal barriers were more pervasive among AA women.

Religiosity plays a role in drug addiction and substance use (Beraldo et al., 2019; Churakova et al., 2017; Ebadi et al., 2018; Greer & Abel, 2017; Sansom, 2018). Greer and Abel (2017) provided insight into the influence of religious coping behaviors in older AA women in a rural medically underserved area. Churakova et al. (2017) and Ebadi et al. (2018) highlighted the social structures that were built into religiosity could allow patients to have positive relationships that are linked to resilience against developing drug abuse problems. Sansom (2018) suggested modeling the characterization of sins, vices, and diseases to ensure patients understood the seriousness of their issues without causing further mental harm. Yeterian et al. (2018) illustrated religiosity could exasperate substance abuse. Beraldo et al. (2019) investigated religiosity and self-awareness within treatment process and found the two factors could determine the success of the strategies to enhance psychosocial issues and the recovery from addiction.

Religiosity has been demonstrated to have an impact on stigma (Abdeslam, 2020; Beraldo et al., 2019; Lund, 2017; Monacis et al., 2017; Petet, 2019; Prosek et al., 2017; Yeterian et al., 2018). Lund (2017) and Prosek et al. (2017) revealed the association of the experience of

shame and religiosity might compound the issue of substance abuse. Monacis et al. (2017) suggested social stigma constituted a crucial support system for young people who were still developing psychologically. Monacis et al. also suggested social stigma was aggravated by that people were living in a period that witnessing the unprecedented technical extension of communication. Petet (2019) examined the role of stigma on addiction management strategies and indicated when religious advisors had inherent prejudice in their belief of the causality of addiction, they were less likely to make substantive referrals. The findings of Matsumoto et al. (2021) suggested importance of strategies to address experiences of discrimination to improve mental health of women in publicly funded substance abuse treatment.

Researchers that have investigated religiosity and drug addiction have made important recommendations for future research. Popovici and Simion (2017) highlighted the link between drug use and religiosity required an in-depth and structured review of the patient's belief system. Dada et al. (2018) recommended additional investigations into the service needs of AA women utilizing substance use treatment. Beraldo et al. (2019) recommended furthering studying the role and impact of religiosity in improving recovery rates among drug addicts. The findings of Oser et al. (2019) stressed the need for prevention and intervention efforts for AA women that highlighted social context influences and promoted greater awareness of the health risks. Hosmane (2019) and Muhamad et al. (2020) proposed religious-based drug and substance use interventions be structured into any religious derived therapy protocols in various forms that were suitable for patients. Hosmane (2019) and Muhamad et al. (2020) argued these structures were necessary for defining the problem, justifying the solutions, and setting realistic, patient-centered goals. Abdeslam (2020) recommended medical personnel mitigate judgmental attitudes within the care framework for patients in recovery.

However, a review of the existing literature on substance abuse reveals few attempts have been made to explore the lived experiences and perceptions of AA women who have experienced religious substance abuse treatment about the role of religiosity in treating substance abuse. In response addressing this gap in research and the continuing the research direction as highlighted by Popovici and Simion (2017), Dada et al. (2018), Beraldo et al. (2019), Oser et al. (2019), Hosmane (2019), and Muhamad et al. (2020), this study aims to explore the lived experiences and perceptions of AA women who have experienced religious substance abuse treatment about the role of religiosity in treating drug and substance abuse.

Situation to Self

I was motivated to conduct this study after years of witnessing the destruction of families and communities due to drug addiction. As an AA woman, I have also felt a connection to the shared racial and gender identities that are held by a disproportionate number of people addicted to drugs and other substances. Although I share identities with the participants in this study, I, nonetheless, brought a constructivist paradigm to this study, as I sought to learn, making no prior assumptions.

Problem Statement

AA women are more likely to die from drug overdose than any other demographic of substance abuse users (Friedman et al., 2022). In addition to the risk of death, other risks such as infective endocarditis are increased with drug abuse (Kadri et al., 2019). The general problem is the ineffective intervention implementations and treatments for individuals abusing drugs (Pinedo et al., 2020; Seifer, 2018; Yeager et al., 2018). The specific problem to be addressed is how AA women perceive the influence of religiosity on their experiences in Celebrate Recovery (CR) groups in central Georgia.

Purpose Statement

The purpose of this qualitative phenomenological study was to explore AA women's perceptions of the influence of religiosity on their experiences in CR groups in central Georgia. The research methodology and design were aligned with a qualitative study. Thirteen AA women in central GA, aged 23 to 63, were interviewed. Participants met the following recruiting criteria: (a) aged between 18 and 30 years old; (b) have experienced drug and substance addiction; and (c) have participated in a CR program. I employed a thematic analysis process to analyze data. This study hopes to fill the gap in knowledge about AA women's perceptions of the influence of religiosity on their experiences in CR groups in central Georgia. This study has practical implications, which could benefit AA women who are seeking drug and substance abuse treatment. The findings of this study could also inform health care professionals, psychologists, and counselors that are working with people committed to drug and substance abuse to understand the role of religion in substance abuse treatment. The theory that guided this study was Parsons's classic structural-functional analysis of religious organization theory because it describes religion as an integrated system of beliefs or practices related to sacred aspects or things responsible for uniting one moral community to which all other things adhere.

Significance of the Study

This study could advance knowledge and contribute to the scholarship of psychology, neuroscience, medical science, and religious substance abuse treatment. Neff et al. (2006) recommended further research on treatment engagement, retention, and other outcomes. Popovici and Simion (2017) highlighted the link between drug use and religiosity required an in-depth and structured review of the patient's belief system. Dada et al. (2018) recommended additional investigations into the service needs of AA women utilizing substance use treatment.

Beraldo et al. (2019) recommended furthering studying the role and impact of religiosity in improving recovery rates among drug addicts. Moreover, few studies have been conducted to explore the role of religiosity in treating drug abuse from the perspectives of AA women who have experienced religious substance abuse treatment. As such, to fill the gap in research and continue the research efforts by Neff et al. (2006) and Beraldo et al. (2019), this study could enrich the literature. The themes and findings that emerged from this study could benefit researchers and scholars in the fields of psychology, neuroscience, medical science, and spiritual medical ethics studies.

Despite severe consequences of individuals abusing drugs, not many interventions have been proven effective for drug abuse recovery (Pinedo et al., 2020; Seifer, 2018; Yeager et al., 2018). Researchers indicated religiosity could play an important role in improving the recovery rates of people committed to substance abuse behaviors (Abdeslam, 2020; Beraldo et al., 2019; Lund, 2017; Monacis et al., 2017; Petet, 2019; Prosek et al., 2017; Yeterian et al., 2018). Yeager et al. (2018) proposed for basic developmental science and improvements to youth policy and practice. Oser et al. (2019) stressed the need for prevention and intervention efforts for AA women that highlighted social context influences and promote greater awareness of the health risks. Hosmane (2019) and Muhamad et al. (2020) proposed religious-based drug and substance use interventions be structured into any religious derived therapy protocols in various forms that were suitable for patients. Abdeslam (2020) recommended medical personnel mitigate judgmental attitudes within the care framework for patients in recovery. Wong et al. (2020) indicated dysfunctional beliefs could mediate treatment effects on negative emotions and subsequently the quality of life. Wong et al. also found female could benefit more in relieving stress and using social support than male.

However, existing evidence suggests few attempts have been conducted to explore the phenomenon, particularly from the perspectives of AA women who have experienced religious substance abuse treatment. Therefore, the findings of this study could benefit AA women who are seeking drug and substance abuse treatment programs. The findings of this study could also inform health care professionals, psychologists, and counselors that are working with people committed to drug abuse and who are struggling with finding effective treatment programs.

Research Questions

The research questions that guided this qualitative phenomenological study are:

RQ1: How do AA women who have participated in CR programs describe their experiences?

RQ2: How do AA women who have participated in CR programs describe the benefits of the program?

RQ3: How do AA who have participated in CR programs describe the role of religion in participating in the program?

RQ4: How do AA women describe their challenges in CR groups?

Definitions

1. *Addiction* – A biopsychosocial disorder (Adamson, 2018; Beraldo et al., 2019). Addiction refers to repeatedly using drugs and engaging in a behavior despite it is harmful to both the individual and others (Adamson, 2018; Beraldo et al., 2019).
2. *Religiosity* – Religious belief or religious feeling (Hilton et al., 2018).
3. *Religious Socialization* – The association with individuals with similar religiosity, who have two primary mechanisms for preventing drug abuse (Peviani et al., 2020).

4. *Stigma* – Disgrace that is linked to a certain circumstance, situation, person, or quality. Stigma is a critical determinant for health-seeking behaviors in drug users (Baumberg, 2016)
5. *Substance Abuse* – Refers to using psychoactive drugs excessively. Substance abuse may refer to the use of alcohol, medications for pain management, or illegal drugs. Substance use can lead to physical, social, or emotional harm (Hilton et al., 2018).

Summary

Chapter 1 focused on introduction. Chapter 1 covered discussions of an overview, the background, the problem statement, the significance of the study, the research questions, the definitions, and a summary. The problem was there was a minimal understanding of how AA women perceive the influence of religiosity on their experiences in CR groups in central Georgia (Beraldo et al., 2019; Dada et al., 2018; Hosmane, 2019; Muhamad et al., 2020; Oser et al., 2019; Popovici & Simion, 2017). Correspondingly, the purpose of this qualitative phenomenological study was to explore AA women's perceptions of the influence of religiosity on their experiences in CR groups in central Georgia. Four research questions guided this qualitative phenomenological study.

Chapter Two: Literature Review

Overview

Researchers have frequently cited ineffective interventions implementations and treatments for individuals abusing drugs (Pinedo et al., 2020; Seifer, 2018; Yeager et al., 2018). The problem is it is unknown the role of religiosity in the treatments for substance abuse from the perspectives of AA women who have experienced religious substance abuse treatment (Beraldo et al., 2019; Dada et al., 2018; Hosmane, 2019; Muhamad et al., 2020; Oser et al., 2019; Popovici & Simion, 2017). The purpose of this qualitative phenomenological study was to explore AA women's perceptions of the influence of religiosity on their experiences in CR groups in central Georgia.

Chapter 2 focuses on the existing literature pertaining to the research problem. A researcher summarizes and evaluates the existing findings, absorbs knowledge and understanding of certain topics under study, and contrasts the viewpoints of previous researchers in a literature review (El Hussein et al., 2017). Chapter 2 includes the major sections of (a) Overview; (b) Conceptual or Theoretical Framework; (c) Related Literature; and (d) Summary.

This literature review correlates the various aspects of religiosity and their impact on various measures such as recovery rates, stigma adaptability, social and internal intelligence, and age and gender. Moreover, the literature around the role of religiosity in the therapeutic space will be examined, with a focus on AA women. I searched literature for peer-reviewed journal articles and doctoral dissertations and begins the search with academic databases such as ScienceDirect and SAGE Journal. In the Related Literature sections, over 90% the sources are from peer-reviewed journal articles and were published between 2017 and 2020.

Conceptual Framework

Parsons's (1937) classic structural-functional analysis of religious organization theory has been selected to ground the current study. Parsons's (1937) structural-functional theory describes religion as an integrated system of beliefs or practices related to sacred aspects or things responsible for uniting one moral community to which all other things adhere. According to Parsons's (1937) theory, religion and spirituality fulfill fundamental social functions and needs for individuals and communities. Further, Parson's (1937) theory posits that religious or spiritual practices serve to promote cohesion among a group of people who share a faith. (Parsons, 1937)**.**

The application of Parsons's (1937) theory to religion-based treatment presents several aspects related to the current study. Parsons's (1937) theory underscores the importance of spirituality and religion in promoting healing among people as the basic treatment for individuals with different problems. The theory is also based on the assumption that spirituality and religion play an important role in individuals' lives by affecting different aspects of life, including their views toward addition and how spirituality promotes a sense of confidence and divine power to rehabilitate the person. Another thing to mention is that Parsons's (1937) theory is based on the premise that therapy's success depends on individuals' level of motivation to participate in the sessions, retention, and the possible outcomes. The above factors are directly influenced by religion and spiritual beliefs toward the treatment methods used to treat substance abuse. Therefore, Parsons's (1937) theory will be used in this study to understand the influence of religiosity on the effectiveness of substance treatment programs among AA women with substance abuse problems.

Parsons's (1937) structural-functional theory has been used to ground similar studies involving religion and its influence on societal systems and issues (Baykal, 2021). Chriss (2020) conducted a study using Parsons's theory as a framework to better understand how religion is used to cultivate social order, conformity, and control. According to Chriss (2020), people with positional power or authority, such as pastors, often use religion to influence others. By conducting this study, I will learn more about the influence of religion on the experience of AA women in CR programs.

Related Literature

AA Women Drug and Substance Abuse

The rate of increase of overdose deaths of AAs has outpaced the rate of increase of overdose deaths of Whites (Stevens-Watkins, 2020). The AA overdose death rate exceeded all other racial and ethnic population groups in the United States (Substance Abuse and Mental Health Services Administration, 2020). From 2011-2016, compared to all other populations, AAs had the highest increase in overdose death rate for opioid deaths involving synthetic opioids (Substance Abuse and Mental Health Services Administration, 2020).

Dada et al. (2018) described changes in patterns of alcohol and drug use among AA women who accessed specialist substance abuse treatment centers by collecting data from 51 specialist treatment centers participating in the Epidemiology Network on Drug Use between 2000 and 2013. Dada et al. found that the women who identified methamphetamine as their primary drug of abuse we more likely to be young AA women than any other group of women. Though, over 25 percent of the women admitted to abusing more than one substance (Dada et al.) Further, Dada et al. found women who identified as White and younger than 25 comprised the largest demographic group of heroin users.

Harp & Oser (2018) examined the influence of child custody loss on drug use and crime among a sample of AA mothers. Specially, Harp & Oser examined the influence of informal custody loss, which refers to child living apart from a mother but courts not involved, and official loss, which is child removed from mother's care by authorities. Using data from 339 AA women, the authors used longitudinal random coefficient models to analyze the effects of each type of custody loss on subsequent drug use and crime. The results indicated that both informal and official custody loss predicted increased drug use, and informal loss predicted increased criminal involvement.

Oser et al. (2019) explored the effects of AA women's social context and substance use perceptions on daily tobacco and marijuana use. Using survey data collected from 521 AA women, Oser et al. employed multivariate logistic models to identify the significant correlates of women's daily use of tobacco and marijuana in the past six months. The results showed 52.59% of participants reported daily tobacco use and 10.56% used marijuana daily. Oser et al. showed women were more likely to be daily tobacco users if they had a family member with a substance use problem or perceived tobacco use to be wrong, harmful, or more dangerous than marijuana. Moreover, the results showed women who lived with a person who used drugs were more likely to use marijuana daily.

Pinedo et al. (2020) explored barriers to specialty substance abuse treatment programs among women with recent substance use disorders by race/ethnicity. Pinedo et al. conducted qualitative interviews with 28 women of White, Black, and Latino racial/ethnic descent who reported a substance use disorder in the past five years. Framed by the Theory of Planned Behavior, the results revealed several key differences in barriers to treatment by race/ethnicity. Specifically, Pinedo et al. found attitudinal barriers were more pervasive among the narratives of

Latinas relative to Black and White women, and Latinas were more likely to report not needing treatment and that treatment would not be effective.

Dada et al. (2018) found that, despite being disproportionately represented in substance abuse data, AA women were increasingly seeking treatment for their struggles with substance abuse, especially their abuse of methamphetamine-related drugs. When seeking to understand some of the contributing factors to increased drug use among AA women, Harp and Oser (2018) found that grief related to the loss of mothers' children contributed to negative health outcomes, including drug or other substance use. However, Harp and Oser (2018) also found that a mother's social resources might serve as supports to deter or mitigate substance abuse issues.

Dada et al. (2018) highlighted the increasing use of substance use treatment services by AA women, particularly for methamphetamine use disorders. Harp & Oser (2018) highlighted the need to integrate drug treatment and other types of assistance into family case plans to improve reunification rates and outcomes among mothers, children, and families. Dada et al. (2018) recommended additional investigations into the service needs of AA women utilizing substance use treatment. The findings of Oser et al. (2019) stressed the need for prevention and intervention efforts for AA women that highlighted social context influences and promote greater awareness of the health risks.

Religiosity Affects Recovery Rates of AA Women

Adamson (2018) and Beraldo et al. (2019) acknowledged the complexity of substance use and abuse at the individuals and societal levels. Religiosity has a complex relationship with substance use. Therefore, they can be used to define and explore its intricacies. Religiosity factors such as attitudes and preferences had a strong association with drug use and the propensity of individuals to seek interventions. This finding lends credence to the use of holistic

approaches in managing drug use and abuse issues in patients. The multifactorial etiology of addiction may mean that religiosity may not have a significant impact on some individuals. Societies that are increasingly linked to religiosity such as minority groups (Latinos, AAs, and Native Americans) are more likely to benefit from these protocols when they are specifically tailored to these sub-segments of the population. They are also practical solutions for areas where conventional therapy may be inaccessible such as in rural environments. Hilton et al. (2018) assert that religiosity also affects the levels of risk of falling into drug and substance abuse patterns. These religiosity factors are inextricably linked to the relationships that individuals tend to keep. Social linkages are an active part of positive or negative re-enforcement for destructive coping models (Drabble et al., 2018; Hilton et al., 2018; Skewes et al., 2019; Spitz, 2018).

When making an examination from a Muslim point of view and using the bio-psychosocial model that connects biological, psychological, and socio-environmental variables and their roles in health and illness, Alighieri et al. (2017) confirmed their relationship with addiction in Amman, Jordan. These factors established that issues such as crime, social isolation, poor family, and marital relationships are directly related to addiction and poor treatment outcomes. Alighieri et al. (2017) highlighted that the difference between religious practice and spirituality, specifically in the Muslim culture should be examined. In Muslim majority countries, there is a tendency to gravitate towards religious practice without the accompanying religiosity. These relationships mitigate the mental health effects of socioeconomic breakdowns.

Most religious doctrines advocate for charitable actions and social responsibility. Studies have shown that there is an active neurological link between charitable works and personal well-being (Konrath, 2016). A functional neural MRI scan of the brain revealed that there was a

subsequent activation of the pleasure and reward centers of the brain. This action-reward paradigm is the system that is linked to the formation of drug addiction (Dafny & Rosenfield, 2017). Sayin (2019) notes that alternatives such as sexual activity, exercise, and social activities such as social gatherings have links to neurobiological activation of pleasure centers. The dopamine released is acceptable as a reward for the brain regardless of the source thus precluding the need to seek pleasure from drugs. This hardwired instinct to seek pleasure is part of the human psyche, and religious activities give the individual an outlet for stress and boundaries for the pleasure-seeking impulses.

Focusing on cannabis, Popovici and Simion (2017) suggested cannabis stand out as a drug that required specific religious interventions that mitigated the argument of choice due to religion. Popovici and Simion also indicated the same case could be made for psychopaths. Greer and Abel (2017) aimed to identify religious coping behaviors of AA women with hypertension (HTN) and explored how religious coping influenced adherence to high blood pressure (HBP) therapy in older AA women. Employing a mixed-method research design, Greer and Abel invited 20 AA women with primary HTN to participate in the study and provide physiologic, descriptive, and sociodemographic data. The authors measured adherence using the Hill-Bone Compliance to High Blood Pressure Therapy scale and evaluated religious coping with the Brief Religious Coping scale. The findings showed the AA women had feelings of dizziness, lightheadedness, and feeling sick. Greer and Abel also found the AA women had belief in God or a Supreme Being, who used prayer as the primary coping mechanism. Additionally, the results indicated adherence was conceptualized as obedience to God's will. Based on the results from the thematic data analysis, Greer and Abel highlighted the need for healthcare providers to pray and provide more health information.

Popovici and Simion (2017) suggested care should be taken when examining religiosity in certain circumstances, for instance, in cases where there are facets that are in support of substance use (Popovici & Simion, 2017). Like Popovici and Simion (2017), Greer and Abel (2017) also argued nurses and other healthcare providers were in a key position to influence positive health outcomes in rural settings with limited resources using culturally appropriate strategies. Napoletano, et al. (2020) suggested self-awareness be built into the first step of the recovery program in which patients admitted to having a problem that was beyond their control.

Greer and Abel (2017) provided insight into the influence of religious coping behaviors on adherence to HTN treatment in older AA women with HTN in a rural medically underserved area. Greer and Abel also argued nurses and other healthcare providers were in a key position to influence positive health outcomes in rural settings with limited resources using culturally appropriate strategies. Popovici and Simion (2017) highlighted the link between drug use and religiosity required an in-depth and structured review of the patient's belief system.

Religiosity Affects Violence, Trauma, and Addiction

Dawley and Thornton (2018) highlighted the significant role religious beliefs had on the advent and propagation of toxic masculinity. Further, Dawley and Thornton highlighted transformational interventions must be built into the protocols of alcoholics anonymous groups. These interventions must include the realignment of definitions of masculinity to mitigate the negative stereotypes that increase the relapse rates among recovering addicts (Beraldo et al., 2019).

The association between addiction and aggressive behavior has been established by literature. Toxic masculinity has also been associated with a tendency towards violent behavior against other men and women. Religiosity in this context has served as an intervening factor in

the propensity to take violent actions. Men in residential addiction therapy, the higher the level of religiosity translated into less violent outbursts (Beraldo et al., 2019). Supporting religious or spiritual interventions in these groups reinforces values and coping strategies that negate the impact of drugs on the male psyche, a vital part of the recovery process.

Toxic masculinity also speaks to the culture that for a long time viewed alcohol and drug use as a desirable trait. In countries where this is still a problem, the prevalence of alcohol and drug addiction in males and the accompanying complications is significantly higher than in women as is the case in Russia (Jargin, 2018). Religion is an essential tool in the acculturation process that can reduce the impact of alcohol use and change the health-seeking behaviors of men in these societies.

Religion in Detoxification and Relapse Prevention

Johnson et al. (2016) compared social support, religiosity, and community service when managing addiction in adolescents. For such volatile populations, a re-examination of criminal justice systems is always necessary. These systems have been found to exasperate drug addiction and criminality. Religiosity and community service have emerged as vital tools for the prevention of relapse in at-risk youths. Religiosity and community service reduces idle time, builds self-confidence, and helps these youths to cope with socio-environmental challenges. Youths are better able to remain sober if they have built-up personal support systems that inform their decision-making, a vital component of the values instilled through religion.

A cardinal aim of drug rehabilitation programs is ensuring that the patient does not relapse. This aim is informed by the fact that except for extraordinary circumstances, individuals must function within the geographical, social, and economic spaces that caused their addiction in the first place. To this end, they should be equipped with the skills and tools to manage stress and

peer-pressure better. von Hammerstein et al. (2018) examined a program that required participants to continue with sessions long-term after initial treatment. With the institution of a mindfulness-based relapse prevention program against the backdrop of traditional relapse prevention strategies, there was a significant increase in the number who included mindfulness in their daily routine (Medlock et al., 2017). This translated to higher attendance rates for subsequent sessions and lower rates of relapse. It is worth noting that mindfulness-based relapse prevention protocols were touted by participants as critical tools for managing stress and peer-pressure (von Hammerstein et al., 2018).

Focusing on resilience resources, Lipira et al. (2019) evaluated whether religiosity, social support, and ethnic identity moderated the effects of HIV-related stigma on depression among AA women living with HIV. Using baseline data during 5/2013 to 10/2015 from a randomized controlled trial to test the efficacy of an HIV-related stigma reduction intervention, Lipira et al. conducted the study among AA women living with HIV in Chicago, IL and Birmingham, AL who were above 18 years old and receiving HIV services. The authors also assessed whether religiosity, social support, and ethnic identity modified the relationship between HIV-related stigma and depression, measured by seven-item Religious Beliefs and Behaviors survey, select subscales from the Medical Outcomes Study Social Support Survey, and Commitment subscale from the Multigroup Ethnic Identity Measure. Lipira et al. conducted three separate moderation analyses using linear regression with interactions between HIV-related stigma and each moderator of interest, adjusted for study site, age, time since diagnosis, and education. The results revealed among 226 AA women living with HIV, greater levels of HIV-related stigma were associated with greater depression in all three models. Lipira et al. highlighted only

religiosity modified this association, with a weaker association among women reporting higher levels of religiosity.

These protocols are integral to the management of mental health issues such as anxiety and depression. These issues directly and significantly affect the ability of the individual to maintain sobriety (Wong et al., 2020). In the same breath, Ghetti et al. (2020) found that music therapy has shown similar therapeutic impact for addiction recovery and relapse prevention. Religion-based programs that incorporate music and mindfulness have a continued therapeutic effect on the patient's ability to remain sober. Moreover, maintenance of family functions as envisioned in religiosity coupled by mindfulness to religiosity is necessary for resilience (Alighieri et al., 2017).

In some patients, severe drug abuse disorders necessitate clinical intervention through detoxification of pharmacotherapy. For these individuals, programs such as the 12-step AA program may not be practicable initially. However, religious coping is a factor in the acute phase of these treatment programs. Religious coping is defined as the ability of an individual to use religion as a tool for explaining and handling extremely stressful situations (Medlock et al., 2017). The acute phase of these programs is marked by extreme withdrawal resulting in intense physical distress. Individuals with high religious coping indexes were more likely to participate in mutual-help programs (Medlock et al., 2017). They were also more likely to have a lower severity index as they seek assistance sooner than those with low religious coping indexes do. Furthermore, they displayed lower levels of drug craving during the initial phases of the program (Medlock et al., 2017). Most importantly, they had a higher confidence level in their personal ability to remain abstinent after being discharged. Churakova et al. (2017) and Ebadi et al. (2018)

highlighted the social structures that were built into religiosity could allow patients to have positive relationships that are linked to resilience against developing drug abuse problems.

Religiosity and Peer-Pressure in Young Adults

The role of peer-pressure in the development of drug habits is a foregone conclusion, particularly for adolescents and young adults. This explains the high drug abuse rates in these demographics. Religiosity plays an important role in mitigating the impact of this pressure. Peviani et al. (2020) defined religious socialization, that is, association with individuals with similar definitions and levels of spirituality has two primary mechanisms for preventing drug abuse. The first of these is creating a physical distance between the individuals and situations that increase the risk of developing a drug habit. The second mechanism is by social pressure to enforce and maintain the values that prevent substance abuse.

According to Monacis et al. (2017), social pressure constitutes a crucial support system for young adults and adolescents who are still developing psychologically. The fact that social influences shape people's customs, judgments and beliefs is a truism that everyone easily accepts. A child masters his "maternal" dialect until he reaches the greatest subtleties; a person from a tribe of cannibals accepts cannibalism as entirely adequate. All social sciences start from observing the profound effects that groups have on their members. This aspect is pertinent to support system for young adults and adolescents who are still developing psychologically. Today, social pressure is aggravated by the fact that we are living in a period that witnessing the unprecedented technical extension of communication, which is intentionally creating the intentional manipulation of opinion and the “engineering of consent” (Monacis et al., 2017) Thus, young adults and adolescents are forming their opinions and the roles played based on social conditions.

Adolescence is described as the period in which one is physically healthiest. However, the behavior of this group, on the other hand, can be dangerous. Substance use increases during adolescence. Substance use can adversely affect adolescent development and health. Adolescence is a period in which the brain is still developing. It is precisely during this period that the brain is therefore extra sensitive to the effects of substances such as alcohol. The phenomenon of drug addiction among youths emerges as a function of social representations (SR), which reflects aspects that allow social groups to communicate, understand each other, elaborate on identities, and explain their realities with common sense reasoning (Monacis et al., 2017). According to Moscovici (21), decision-making are reasoned products that underlie knowledge and belief systems that revolve around the object. These arguments are not the product of elaborate theories; they come from the common sense with which individuals operate in their daily lives to solve their problems. In other words, SRs are a form of social thought that include, beliefs, images, attitudes, practices, and experiences that guide decision-making posteriori. From this perspective, religiosity/ spirituality offers potential avenues that can the youth reframe their thoughts, altitudes, and beliefs, which can help them, avoid drugs, or stop using them.

The Concepts of Sin and Shame in People Addicted to Drugs

The characterization of sins, vices, and diseases must be modeled to ensure the client understands the seriousness of the issue without causing further mental harm (Sansom, 2018). The experience of shame, secondary to religiosity occurs more frequently in cases of alcohol use disorder (AUD). This association does not translate to health-seeking behavior but may compound the issue of alcohol and substance abuse (Lund, 2017; Prosek et al., 2017).

In recent years, the so-called "dual pathology" has been current. This term refers to concurrence in the same individual of at least one substance use disorder and one other psychiatric disorder (for example, major depression). These “dual” patients are especially serious patients from both the clinical and social perspectives and constitute a therapeutic challenge not only individually, but also for health systems, which must deal with complex patients straddling two different healthcare networks: drug addiction network and mental health network (Prosek et al., 2017). These people with the coexistence of addictive disease and other mental pathologies go to emergency services more frequently and require more psychiatric hospitalizations. This is because they display more at-risk behaviors and related infections such as HIV infection and the hepatitis C virus (Lund, 2017). Moreover, they are associated with higher rates of unemployment and marginalization and more violent and criminal behaviors than those with only a diagnosis of drug addiction or a diagnosis of another psychiatric disorder. In other words, they are serious individuals from a psychopathological, medical, and social perspective.

The reliable and valid identification of a diagnosis of psychiatric comorbidity in subjects who are using psychoactive substances raises two fundamental problems. On the one hand, the acute and chronic effects of drugs on the central nervous system simulate symptoms of many of the mental disorders. For example, insomnia produced by acute cocaine consumption, indistinguishable from insomnia in psychiatric diseases such as depression. In turn, this makes it difficult to differentiate between the psychopathological symptoms of the acute effects of substance use or withdrawal from those of an independent psychiatric disorder.

Therapists must be aware of this fact when handling clients with fragile mental states coupled with shame. Hence, maintaining a therapeutic alliance with clients who demonstrate co-current disorder (COD) is a critical and difficult aspect. Street and Moyle (2019) emphasized the

importance of the counselors address other fragile mental states when working with these clients. Clinicians alongside clients must monitor any state of fragility or feeling of shame. Individuals with COD often experience demoralization and despair because of the increased complexity of treating multiple disorders and the difficulty of achieving successful treatment. Often, inspiring hope is a necessary precursor for the client to give up short-term relief in exchange for long-term recovery with some uncertainty about the term and benefits. The recovery of initials with co-occurring disorders also demonstrates a high level of religious faith. However, they tend to identify with the latter rather than the former. Lund (2017) explained that this aspect is associated with a more optimistic outlook on life, with the perceived social support; therefore, religion provides a coping mechanism.

Causative Role of Religiosity in Drug Addiction

The causative role of religiosity is particularly true for individuals who suffer isolation and shame because of retreating from the basic tenets of their religions. Some communities do not view some forms of drug use as an addiction, but rather as a means of seeking a higher purpose and connection (Stevenson, 2018). Rehabilitation is complex and may be met with resistance as individuals are typically rooted in their beliefs on religion. The anthropological examination of religion offers a possible model for mitigating such issues (Napoletano, et al., 2020). Self-awareness magnifies the ability to accept the problem and seek treatment. Hence, it is built into the first steps of the recovery program in which the patient admits to having a problem that is beyond their control.

The hippie movement of the mid-20th century is an example of a counterculture whose basic tenets instigated and supported an explosion of addiction and drug abuse. Many hippies were against the ideas advanced by mainstream religions and instead advocated for personal

spiritual experiences. This aspect led to a loosely translated set of beliefs that ranged from the occult to modified versions of Buddhism (Stevenson, 2018). Boudreau (2018) notes that within this paradigm, the phenomenon of better living through chemistry with a wide range of drugs involved.

This search for connection and enlightenment was linked to the use of psychoactive chemicals and drugs such a psychedelic mushrooms and cannabis (Napoletano, et al., 2020). It also eliminated the boundaries that had been set by mainstream religions against what were considered vices as the movement forced the re-examination of religious dogma and doctrines across the spectrum. Religious-based drug and substance use interventions must be structured into any religious derived therapy protocols in various forms that are suitable for the client (Hosmane, 2019; Muhamad et al., 2020). These structures are necessary for defining the problem, justifying the solutions, and setting realistic, patient-centered goals (Hosmane, 2019; Muhamad et al., 2020).

Stigma Impacts Drug Addicts and Substance Use

Stigma is a critical determinant for health-seeking behaviors in drug users. Experiences of perceived stigma and discrimination are associated with a range of negative health outcomes (Matsumoto et al., 2021). Individuals with substance use disorders and co-occurring mental health problems experience significant public stigma and discrimination associated with multiple aspects of identity (Matsumoto et al., 2021).

Baumberg (2016) highlighted its role in discouraging the uptake of social services particularly by individuals in need. This affects the 'deservingness' component that links to the uptake of support systems. These findings show that there is a need for in-built shame and stigma mitigation measures. This would contribute to the tendency to seek help, particularly for drug

users. Abdeslam (2020) builds on this to recommend that medical personnel should mitigate judgmental attitudes within the care framework for patients in recovery. Uptake of care by drug users is dependent on the feeling of empathy from the caregivers. Further, the study links religion to such outcomes as abandoning suicidal ideation, acceptance of addiction as a disease, and uptake of positive coping strategies for the patients (Horton et al., 2016).

Despite the role that religion plays in fomenting the social stigma directed against addicts, it can be a vital tool for relieving the same negative impact. In ex-convicts who are also recovering addicts, religious organizations are an important community re-entry point. Apart from offering mental and economic support, they also provide the individual with the opportunity for reintroduction into the social circles. They are an important mediator against the stigma associated with a criminal and drug use history. The role of religious values of forgiveness and acceptance for all who are willing to change cannot be understated as stigma results in isolation, which may precipitate a relapse (Braun et al., 2018).

The distinction between disease and moral shortcomings for drug addicts may be a significant determinant of their willingness to seek and enroll in recovery programs. Henderson and Dressler (2017) note that the cultural causality models of addiction are shared by individuals in heterogeneous communities. These causality models determine the level of socially instigated stigma against substance abuse. Individuals within communities with a higher affinity to scientific causal models (genetics and stress) were less likely to stigmatize individuals with mental illness, particularly drug abuse. This opens the discussion of the causal framework of stigma in heterogeneous religious communities. Henderson and Dressler found that church attendance was linked to higher attributions of stigma. Interestingly, men were less likely to stigmatize than women.

Petet (2019) examined the stigma against mental health that was religiously reinforced. The role of this stigma on the addiction management strategy was also examined. When religious advisors have inherent prejudice in their belief of the causality of addiction, they are less likely to make substantive referrals. This is based on the belief in diabolical causation. Further, it leads to downplaying of the danger attributed to addictions of any form. This is an indictment of the entire process of religious-based therapy for addiction. It calls for a structured approach of addiction intervention that mitigates this bias in the religious advisors and manages the impact of stigma due to diabolical causal models of mental health issues.

Forgiveness and acceptance are also central tenets of the 12-step program. This is an indicator of the need to mitigate religious-based stigma among therapists. The actions of an individual that are linked to the period of addiction must not prejudice the practitioners' ability to guide them through the program. Providing a forum where all individuals are accepted despite the challenges that they face is the definition of built-in stigma prevention. This is an echo of the religious roots of the 12-step program. Further, it may also explain the popularity of such programs among individuals seeking accessible therapy. Ashford et al. (2019) determined that eliminating labels such as 'drug user' and 'addict' has a significant impact on the therapists and patients' feelings of stigmatization. Acceptance builds a social bond that is devoid of prejudice, which can have positive influences on health seeking and adherence to regimens.

Combating stigma enhances the patients' feeling of being accepted. Bar-Sela et al. (2020) asserted that the feeling of being embraced enhances the drug users' feeling of self-awareness. This is in opposition to the role of stigma as a barrier to the recovery process. Thus, it is important to note that religious activities can serve as a vital outlet for stigmatized individuals. Neysiani et al. (2019) identified that for many women, avoidance of drug and substance use is

linked to the uptake of religious activities. This is a common strategy in cases of violence against women.

Trauma and addiction are linked in a cyclic process. Therapists must identify the religious strengths of their client in the spirit of allowing change to happen rather than forcing it. Hence, it has been noted with concern that some therapists have not been able to meet the religious needs of their clients. The safe point of view understands that all religions seek to acknowledge the presence of something greater. Staying away from conflicts and ambiguity is a vital skill for practitioners seeking to take full advantage of the patient's beliefs. Spirituality can be used for targeted therapy for trauma allowing clients to reconnect with realities of life and regain a sense of purpose (Bray, 2019a; Bray, 2019b; Giordano et al., 2016). This does not necessarily occlude therapists from utilizing their religious strengths to care for clients so long as they do not become obtuse and confrontational.

AA women living with HIV report substantial HIV-related stigma and depression (Lipira et al., 2019). The results of Lipira et al. (2019) suggested the protective effects of religiosity could be leveraged in interventions for AA women living with HIV struggling with HIV-related stigma. Pinedo et al. (2020) found within the subjective norms domain, namely stigma and lack of support, were key barriers for AA women. The results of the study also showed stigma was more pervasive among the narratives of Latinas and AA women than White women.

Matsumoto et al. (2021) examined experiences of perceived stigma and discrimination as well as associations among these experiences and poor mental health among women in publicly funded substance abuse treatment services. Employing structured interviews with 240 women, with 59% racial/ethnic minority aged 33 years old on average, Matsumoto et al. measured devaluation stigma, perceived discrimination, and symptoms of psychological distress and

posttraumatic stress disorder (PTSD). The authors also explored the experiences of stigma and discrimination using open-ended questions. The results revealed substance use as the most prevalent source of devaluation stigma and the most common reason for experiences of discrimination. Adjusting for covariates, Matsumoto et al. found discrimination was associated with higher severity of mental health symptoms and PTSD symptoms, while devaluation stigma based on race, substance use, and mental illness were not associated with mental health indices. In addition, the results revealed recent trauma experience partially mediated the relationships of perceived discrimination with mental health symptoms and PTSD symptoms. The findings of Matsumoto et al. (2021) suggested importance of strategies to address experiences of discrimination to improve mental health of women in publicly funded substance abuse treatment.

Factors Enhancing the Impact of Religiosity on Recovery Rates

The fact that religiosity is vital for recovery from addiction has been shown in numerous studies. These studies must illuminate the specific aspects of religion that are responsible for the recovery of addicts. These are discussed in this segment of the literature review.

Age and Gender Affect the Depth of Religiosity and Recovery

Age and gender are determinants for the development and progression of mental health disorders. These are also vital determinants for the coping mechanisms and the effectiveness of the intervention strategies because individuals of different ages are at risk of developing drug problems of distinct forms. These must therefore be addressed within the addiction therapy process. Reinforcing this, Phimphakarn et al. (2020) showed that poor depression and emotional management strategies are evident in freshmen. This raises issues when emotional management was a key tool in managing stress and depression. The ability of the young participants to confront their issues and manage their emotions was low.

Studies link gender to different addiction and mental health issues. w et al. (2016) and Debnam et al. (2018) examined age and gender in combination. In adolescents, this combination of factors and stress act as causative agents for substance abuse. High-stress levels increase the risk of alcohol, tobacco, and other substance abuse. One must note, however, that the stressors, in this case, were all related to school life. For men enrolled in abstinence-based treatment protocols for chemical addiction spirituality and religiosity did not correlate to higher well-being ratings. This is a contradiction to the findings for women. This difference may be an indicator of the gender-specific socio-cultural dynamics that surround religiosity that is accompanied by risks of suicidal ideation in men in the initial stages of recovery (Allanson, 2019; Currier et al., 2020). This shows that gender could be a major determinant for the protocol design in any religiosity - based intervention for substance use and addiction.

In addition, Witkiewitz et al. (2016) acknowledged the reinforcement role of religiosity in mitigating the risk for alcohol abuse. Coupled with gender, religiosity is a mitigating factor for women, in preventing the causative factors such as stress and trauma from evolving to alcohol use disorder (AUD). Practices such as meditation and prayer are central coping tools in all transformative religions. These can therefore be used in therapy for AUD.

In most individuals, the mental stability and ability to cope is enhanced with age. Commitments such as relationships and jobs are indicators of socio-environmental support systems and individual capacity to manage stress. For recovering addicts, particularly in the 12-step Alcoholics Anonymous program, recognition of an authority that is greater than the self is a cornerstone of the recovery process (Halbert, 2020). Dossett (2020) links this to the basic tenets of sticking to commitments, such as attending meetings and following through with the

requirements of the program. Individuals who can maintain these commitments are more likely to have positive outcomes from recovery programs.

Age, particularly among younger clients, has a positive correlation with religiousness. This speaks to the developmental basis of belief systems and vigor. Further, older clients show little change in religiosity indicators. In turn, this aspect may be an indicator of a structured religious, belief system that is a product of lifelong experiences. For this generation of cohorts, practitioners should seek to illuminate these systems (Montes & Tonigan, 2017). While for younger clients, therapists should seek to influence belief systems.

Community and Connection

The most fundamental aspect of any religion is the communal nature of beliefs and spirituality. Mainstream religions emphasize the need to congregate or take part in communal doctrines such as prayer and holidays. This sense of community enhances the formation and maintenance of social support structures such as family, friendships, and relationships with religious leaders. These are important determinants for reduction of the risk of drug use and addiction, prompt identification of problem behaviors and attitudes, prompt intervention, and support during the recovery process. The sense of community also helps to alleviate the feeling of isolation that is one of the leading causes of drug use among individuals across age groups and sexes.

An important indicator of the quality of life of an individual is the level of social connection that they can form. This is important for recovering addicts and at-risk individuals. Demir-Dagda and Child (2019) find that being able to function within this community is part of the input required to improve satisfaction with life. Religious communities are the most common

forms of social interactions after the family. They are both crucial for healthy coping and psychological wellbeing.

For many adherents to mainstream religion, communal communication sessions such as testimonies can produce similar satisfaction levels to those caused by group therapy (Tangalo & Massi, 2018). In these settings, individuals are afforded an opportunity to release stress and connect with others through talking, as is the case in many group therapy sessions. The transactional nature of these sessions is akin to that of group therapy where Tangalo and Massi (2018) found that the interactions of intra-psychic and relational elements are engaged in the exploration of sense, and purpose. For those in the congregation, relating to the issues articulated forms a comradely that supports positive interventions such as prayer, meditation, and seeking counsel from professionals and religious leaders. Religious leaders are vital for monitoring and supporting at-risk individuals and addicts in recovery (Ahmed et al., 2019). In addition, Ortega (2019) found that many individuals find it easier to speak to religious leaders particularly in highly structured religious communities as they are seen as the ultimate reference points for crises and conundrums due to the shared belief systems. Moreover, Alighieri et al. (2017) suggested maintenance of family functions as envisioned in religiosity coupled by mindfulness to religiosity was necessary for resilience.

Acceptance of Higher Power and Relinquishing Control

One of the most outstanding facets of mainstream religions is the acceptance of a higher power. Apart from accepting the existence of such an entity, the practitioner must recognize that the entity has ultimate control over their lives. Muhammad et al. (2019) state that this aspect is enforced by a punishment-reward system, which links consequences of actions and the enforcement of value systems. For most addicts, loss of control over their lives through major

stressor events (deaths, divorce, loss of employment, or social strife) is the initiation point for their addiction (Krause et al., 2017). The need to find reason and control over one's life exasperates previous drug use. The search for an escape is destructive. Krause et al. (2017) posit that religion provides solace for many individuals by providing an outlet (prayer and meditation), tentative reason (higher purpose), and the reassurance that someone or something powerful is in control of the situation. This reduces the risk of developing drug habits and increases the ability to manage the recovery process effectively.

Summary

Simpson's (2004) treatment process model is an appropriate conceptual framework to ground this study. The treatment process model suggests sequential relationships between patient and treatment program attributes, early patient engagement, recovery stages, retention, and favorable outcomes along with behavioral, cognitive, and skills training interventions are effective for enhancing specific stages of the patient recovery process (Neff et al., 2006; Simpson, 2004). The treatment process model is appropriate for this study considering its high relevancy to studying faith-based substance abuse treatments.

To build a foundation of the research and reveal the gap in knowledge, I reviewed literature related to AA women drug and substance use, religiosity on addiction and substance use, the impact of stigma on drug addicts and substance use, and factors enhancing the impact of religiosity on recovery rates. In the reviewing the role of religiosity in addiction and substance use, the following themes emerged: (a) religiosity affects recovery rates of AA women; (b) religiosity affects violence, trauma, and addiction; (c) religion in detoxification and relapse prevention; (d) religiosity and peer-pressure in young adults; (e) the concepts of sin and shame in addicts; and (f) causative role of religiosity in drug addiction. In reviewing the factors that can

enhance the impact of religiosity on the drug and substance use treatment, the following topics were also explored and synthesized: (a) age and gender affect the depth of religiosity and recovery; (b) community and connection; and (c) acceptance of higher power and relinquishing control.

Drug and substance use is particularly prevalent among AA women (Dada et al., 2018; Harp & Oser, 2018; Oser et al., 2019). Dada et al. (2018) highlighted the increasing use of substance use treatment services by AA women, particularly for methamphetamine use disorders. Harp & Oser (2018) highlighted the need to integrate drug treatment and other types of assistance into family case plans to improve reunification rates and outcomes among mothers, children, and families.

Religiosity plays a role in drug addiction and substance use. Greer and Abel (2017) provided insight into the influence of religious coping behaviors on adherence to HTN treatment in older AA women with HTN in a rural medically underserved area. Churakova et al. (2017) and Ebadi et al. (2018) highlighted the social structures that were built into religiosity could allow patients to have positive relationships that are linked to resilience against developing drug abuse problems. Sansom (2018) suggested modeling the characterization of sins, vices, and diseases to ensure patients understand the seriousness of their issues without causing further mental harm. Beraldo et al. (2019) investigated religiosity and self-awareness within treatment process and found the two factors could determine the success of the strategies to enhance psychosocial issues and the recovery from addiction.

Religiosity influences stigma, which then affects substance abuse behaviors. Monacis et al. (2017) suggested social stigma constituted a crucial support system for young people who were still developing psychologically. Social stigma is aggravated by that people are living in a

period that witnessing the unprecedented technical extension of communication (Monacis et al., 2017). Petet (2019) examined the role of stigma on addiction management strategies and indicated when religious advisors had inherent prejudice in their belief of the causality of addiction, they were less likely to make substantive referrals. The findings of Matsumoto et al. (2021) suggested importance of strategies to address experiences of discrimination to improve mental health of women in publicly funded substance abuse treatment.

Age, gender, community and connection, and leadership have been demonstrated to impact individuals' religiosity, and subsequently patients' recovery from substance abuse. Phimphakarn et al. (2020) demonstrated poor depression and emotional management strategies were evident in freshmen. Further, Ortega (2019) suggested speaking to religious leaders particularly in highly structured religious communities as they were the ultimate reference points for crises and conundrums due to the shared belief systems.

Despite the role of religiosity in treating drug and substance use, particularly among AA women, as suggested by previous researchers, Greer and Abel (2017) argued nurses and other healthcare providers were in a key position to influence positive health outcomes in rural settings with limited resources using culturally appropriate strategies. Like Popovici and Simion (2017), Greer and Abel (2017) also argued nurses and other healthcare providers were in a key position to influence positive health outcomes in rural settings with limited resources using culturally appropriate strategies.

Researchers that have investigated religiosity, addiction, and substance use have made practical implications. Oser et al. (2019) stressed the need for prevention and intervention efforts for AA women that highlighted social context influences and promote greater awareness of the health risks. Hosmane (2019) and Muhamad et al. (2020) proposed religious-based drug and

substance use interventions be structured into any religious derived therapy protocols in various forms that were suitable for patients. Hosmane (2019) and Muhamad et al. (2020) argued these structures were necessary for defining the problem, justifying the solutions, and setting realistic, patient-centered goals. Abdeslam (2020) recommended medical personnel mitigate judgmental attitudes within the care framework for patients in recovery.

Researchers that have investigated religiosity, addiction, and substance use have made important recommendations for future research. Neff et al. (2006) recommended further researching on treatment engagement, retention, and other outcomes. Popovici and Simion (2017) highlighted the link between drug use and religiosity required an in-depth and structured review of the patient's belief system. Dada et al. (2018) recommended additional investigations into the service needs of AA women utilizing substance use treatment. Beraldo et al. (2019) recommended furthering studying the role and impact of religiosity in improving recovery rates among drug addicts.

However, a review of the existing literature pertaining to the research problem also reveals few attempts have been made to explore the lived experiences and perceptions of AA women who have experienced religious substance abuse treatment. In response to filling this gap in research, this study aimed to explore this phenomenon from the lived experiences and perceptions of AA women aged between 18 and 30 years old.

Chapter Three: Methods

Overview

The purpose of this qualitative phenomenological study was to explore AA women's perceptions of the influence of religiosity on their experiences in CR groups in central Georgia. Chapter 3 will focus on methods. Chapter 3 will include sections and discussions of an overview, the research design, the research questions, the participants and setting, the instrumentation, the procedures, and the data analysis. The research methodology and design will be a qualitative phenomenological study.

Design

I chose a qualitative research methodology for this study because of its alignment with the study's problem, purpose, and research questions. Qualitative methodologies are best used when researchers seek to explore or better understand phenomena (Yin, 2014). Further, by conducting a qualitative study, I was able to gather data from participants with first-hand knowledge and experience related to the central phenomenon and analyze that data to derive my own meaning (Yin, 2014).

The research explored AA women's perceptions of the influence of religiosity on their experiences in CR groups in central Georgia. Qualitative methodology was utilized because the study sought to examine the phenomena through an in-depth analysis. According to Glesne (2006), qualitative research methods are used to understand a social phenomenon from the perspectives of those involved in that phenomena. As such, qualitative research methodology was used to explore the lived experiences of AA women regarding the use of spirituality to treat substance abuse problems. Qualitative methodology allows for research to be conducted in a naturalistic state versus a manipulated setting, which, was in alignment with the purpose of this

study (Yin, 2014). The methodology was compatible because I explored how AA female describe their lived experiences of using spirituality in their treatment for substance abuse.

The research design for this study was based on the transcendental phenomenology pioneered by Edmund Husserl (Moustakas, 1994). The fundamental purpose of transcendental phenomenology is to establish the common or shared traits, beliefs, perceptions, and experiences that a certain group of people have regarding a particular phenomenon. Researchers use transcendental phenomenology to arrive at detailed descriptions of the nature of a certain group of people or phenomenon. Moustakas (1994) noted that transcendental phenomenology is used to explore and understand participants' descriptions of everyday life experiences. A phenomenological research design aligns with this study because the investigator explored how AA females describe their lived experiences of using spirituality to treat substance abuse. Moustakas (1994) also noted that researchers use transcendental phenomenological study design to attach meaning to participants' descriptions of their lived experiences. In this case, the aim is to reduce participants' descriptions to depict their perceived reality (Moustakas, 1994). This makes transcendental phenomenological research design appropriate for this study because the intent was to use participants' descriptions to portray the AA female reality of using spirituality in their treatment for substance abuse.

Research Questions

The 4 research questions that guided this qualitative phenomenological study are:

RQ1: How do AA women who have participated in CR programs describe their experiences?

RQ2: How do AA women who have participated in CR programs describe the benefits of the program?

RQ3: How do AA who have participated in CR programs describe the role of religion in participating in the program?

RQ4: How do AA women describe their challenges in CR groups?

Setting

The study was conducted in central Georgia in the United States of America. The region is significant because many cases of drug addiction and alcoholism characterize it. In addition, the population of people struggling with drug and alcohol abuse in the study area has been rising recently. For instance, the number of rehab admissions in the region increased by about 11% during the 2017-2019 period. Therefore, central Georgia provides an ideal place for understanding AA's perception of CR due to the prevalence of alcohol addiction and CR groups. AA and CR are two of the standard addiction prevention and recovery strategies utilized by target groups in the study area. However, this study was limited to participants in CR groups. Consequently, limiting the scope of the study to the central Georgia area allowed me to gain an in-depth understanding of how AA women perceive the influence of religiosity on their experiences in CR groups.

Participants

The general population of the study included AA women at least 18 years old in central GA. The targeted population was AA women in central GA that meet the recruiting criteria, a number that is sufficient for the type of in-depth, phenomenological study I will conduct (Moser & Korstjens, 2018). The criteria included: (a) aged between 18 and 30 years old; (b) have experienced drug and substance addiction; and (c) have participated in a CR program.

A purposeful sampling technique was used to select 13 participants that met the criteria. Purposeful sampling was preferred because it was easier to generalize the findings because all participants had similar characteristics (Etikan et al., 2016). Purposeful sampling technique was also extremely cost and time effective compared to random sampling or any other technique because the technique involved a targeted approach to gathering only participants who met criteria that deemed them eligible for a study (Etikan et al., 2016).

Procedures

To obtain approval to conduct the study, I submitted an application to Liberty University's institutional review board (IRB). The IRB reviewed the information contained in the application, such as the purpose of the study, the procedures, and other pertinent information about the feasibility and safety of the study. After receiving an IRB approval number, I proceeded with the recruitment of study participants.

To reach saturation, I aimed to recruit at least 10 AA women who have participated in CR programs within the 5 years prior to the study, and 13 participants who met the criteria were, ultimately, interviewed. I contacted CR program administrators and asked them to disseminate information about this study to AA women who have participated in their programs. I created a flyer that contained information about the study such as the background, sample questions, and my email address for participants to use if participants wanted more information or if they wished to express an interest in participating in the study. Participants who sent an email to express interest in the study were emailed a consent form that included information about participants' rights and ways their privacy would be protected. The consent form also informed participants that they should send an email stating, "I consent", if they wished to move forward with participation.

The Researcher's Role

Qualitative researchers must be aware of their roles as interpretivists of qualitative data and the potential for biases, relationships, or positionality to influence a study (Ravitch and Carl, 2021). To mitigate potential bias or influence over the study, I made sure to have no familial relationships nor friendships with any of the participants. Further, as researcher, I had no personal connection to the research setting and no personal experience with drug addiction. I do identify as Christian and was aware of CR programs prior to conducting this study. However, I had no prior assumptions about the participants nor their participation in CR programs.

Data Collection

I conducted semistructured interviews to explore AA women's perceptions of the influence of religiosity on their experiences in CR groups in central Georgia. Prior to asking interview questions, I explained the significance of the study, including its contribution to knowledge advancement and practical implications to the participants. I ensured all the participants were aware of their right to withdraw consent to participate in the study at any time and for any reason. Further, I informed all the participants of the benefits and risks of taking part in the study. I assured participants that their private information would be kept confidential. Further, participants' identities were concealed by the use of pseudonyms rather than participants' actual names.

Using the interview protocol (see Appendix A) as a guide, I conducted semistructured interviews via Zoom. Each participant was asked the series of questions, with follow-up or probing questions used as needed. In addition to the interviews being recorded, I took notes and kept a reflexive journal while listening to participants' responses. Doing this allowed me to record initial reactions to the data and aided me in the thematic analysis process (Ravitch & Carl,

2021). Each interview lasted about half an hour and was recorded. At the conclusion of each interview, participants were reminded that they may withdraw consent at any time and that their data will be kept in a secure location on a flash drive. All data will be destroyed after 5 years. The interview recordings were transcribed using Otter, a computer software that produces written transcripts of audio data.

Interviews

To recruit participants for virtual interviews, the researcher contacted CR program administrators and requested that they disseminate information about this study to AA women who participated in their programs. A flyer that contained information about the study, including the researcher's contact information, was shared with interested participants. Only participants who met the following eligibility criteria were invited to participate in this study: (a) aged between 18 and 30 years old; (b) have experienced drug and substance addiction; and (c) have participated in a CR program. The virtual interviews, which were conducted via Zoom meetings, involved all thirteen conveniently sampled participants engaging at different times. In particular, the subjects were encouraged to answer eleven questions. The researcher reached saturation because the same recurring themes emerged from the data collected from 13 participants (Ravitch & Carl, 2021). Overall, the questions were sufficient to collect the necessary information for answering the research questions.

Virtual interviews were adopted for the study because they allowed the researcher to engage participants virtually from different locations and coordinate their schedules more conveniently. This data collection method was also approved by the IRB. In addition, the investigator gained the participants' informed consent before conducting the interviews (Roberts et al., 2021). The subjects were also assured of their anonymity and data confidentiality. Thus,

the virtual discussions followed all the necessary technical and ethical procedures of credible research work.

Online semistructured interviews were conducted in this study to gather data from 13 AA women aged 18 and older who have participated in CR programs within the 5 years prior to the study. Online interviews were applicable because of the tight schedule of most study participants that were working full time, which limited their availability for physical interviews. Further, conducting interviews in this manner allowed the researcher to accommodate participants who might have been apprehensive about meeting face-to-face during the COVID-19 pandemic. Participants who met the criteria were purposefully selected to take part in virtual interviews based on their lived experiences and perceptions of the issues surrounding drug and substance abuse.

To ensure the interviews were consistently conducted, the researcher used the interview protocol (see Appendix A) that the researcher created to guide the semistructured interviews. The interview protocol includes open-ended questions. The primary questions that were used to gather data related to the RQs are:

1. What made you choose to participate in the Celebrate Recovery program you selected?
2. Describe your overall experience in the Celebrate Recovery program.
3. Describe the aspects of the program that made you feel supported.
4. Describe aspects of the program you found challenging.
5. Tell me about any part religion might have played in your recovery and how it affected you.

Question one was asked of each participant to gain an understanding of their reason for choosing the program they enrolled in. The responses to this question led to a better

understanding of the role religion played, if any, on a participant's decision to participate in a CR program. Questions two, three, and four were asked to gain a better understanding of the participants' experiences. As Creswell and Creswell (2018) stated, interview questions should be open-ended and provide an opportunity for the researcher to learn more about the central phenomenon from those with first-hand experience. Question five served as the question that offered an opportunity for participants to directly answer the RQ.

Other questions were asked to collect demographic information about the participants. The data collected from participants' responses to the questions below were analyzed to determine whether patterns exist among participants in the same age range (within 2 years of one another):

1. How old are you now and how old were you when you began the CR program?
2. How long did you participate in the CR program?

Open-ended interview questions provide a flexible structure for participants to share freely about their experiences (Creswell & Creswell, 2018). The objective of the online interviews was to obtain the participants' responses and to conduct analysis based on the questions raised about the influence of religiosity and spirituality on AA women's experiences in CR programs.

Data Analysis

The data analysis procedure was modeled after a multi-step process developed by Braun and Clarke (2006). Braun and Clarke (2006) suggested using a multi-step, inductive thematic analysis process to analyze qualitative data:

1. Transcribe the data using Otter, a software program that produces written transcripts of audio data.

2. Read and reread the transcribed data in full to gain familiarity.
3. Manually code the data by using an Excel spreadsheet to group statements that express similar ideas, perceptions, or experiences.
4. Identify themes by grouping codes into a smaller number of more comprehensive themes or sub-themes.
5. Review and refine the themes by comparing them to the original data to ensure they accurately represent the patterns in the data. Through this iterative process, other themes may emerge.
6. Name and define the themes.
7. I conducted member checking by emailing the participants with the identified themes to ensure an accurate understanding of the data. Member checking also ensures the credibility of the study (Ravitch & Carl, 2021). Meanwhile, I also examined the literature to determine if the themes identified were supported by past research.
8. Present the results.

I transcribed the data using Otter, a software that produces written transcripts from audio recordings. After all data were transcribed, I thoroughly read the transcribed data, while listening to the recorded data, to ensure that there were no inaccuracies. While reviewing the transcripts, I composed field notes to record initial reactions, including any patterns I noticed among the data. O'Kane et al. (2021) suggested that qualitative data analysis may be accomplished using inductive methods, which I employed for this study. Rather than approaching the data analysis process with predetermined codes or categories, I identified the codes by summarizing pieces of data collected from participants. I continued to record analytic field notes to monitor any biases

that might have arisen and minimize potential compromises to the trustworthiness of the study (Creswell & Creswell, 2018). Further, Creswell and Creswell (2018) suggested member checking be done to allow participants to review the data for accuracy. I emailed participants copies of their transcripts and initial codes and asked participants to respond, via email, with any proposed amendments, if necessary. There were no proposed changes; therefore, I proceeded with the data analysis process.

The next steps I took guided me toward identifying themes. The initial codes were further analyzed and grouped according to similarities. This process is also known as axial coding and involves the categorization of codes that represent similar ideas (Saldaña, 2016). Lastly, the categories were closely examined to find themes among them that answer the research question and broadly describe the data set (Lester et al., 2020). Below is a detailed description of the thematic analysis process I used.

Phase 1: Becoming Familiar with the Data

Phase one involved becoming familiar with the data. Accordingly, it entailed studying collected data to identify significant errors and duplicates. During this phase, I recorded field notes, or ideas and questions related to the raw data (Lester et al., 2020). Lester et al. (2020) noted that it is helpful to approach this phase as the initial stage of the thematic analysis, where a researcher identifies participants' ideas and experiences vis-à-vis the research phenomenon. This initial understanding helps informs a researcher's detailed analysis during the advanced phases. Therefore, phase one is essential for laying the foundation for a comprehensive study in the subsequent stages of the QDA. I transcribed the data using Otter, a software that converted the audio recordings of the interviews into text. I reviewed the transcribed data for accuracy and made corrections as needed.

Phase 2: Finding Initial Codes

Phase two entails finding initial codes, which are short descriptive phrases depicting the meaning of data regarding elements of analytic interest (Lester et al., 2020). The overarching goal of this stage was to gain a general overview of the collected data by reading, summarizing, and synthesizing the information the research. I organized the transcribed data to prepare the data for coding. A table was created for each interview question and all corresponding responses to that question. This is known as category-based analysis and allowed me to easily look for patterns among the data (Kuckartz, 2019).

After the transcribed data were organized, I began to manually code the data using a color-coding system. Manually coding the data allowed me to become further immersed in the data (Ravitch &.Carl, 2012). Each time a new code was identified, I used a new color to highlight that code. All other data that supported that code were highlighted in the same color. This allowed me to see the prevalence of that code among the data.

Phase 3: Identifying themes

Phase three concerns identifying themes and summarizing them to establish recurrent ones. According to Lester et al. (2020), themes naturally align with the study's conceptual goals. Consequently, the design must respond to specific research questions. Therefore, this phase is critical for crafting appropriate themes that help answer the four research questions.

Phase 4: Reviewing Themes

I reviewed the themes in phase four to ensure that the themes were relevant and accurately represent the data. The stage entails ensuring the themes usefully and accurately depict the data. Thus, I compared the themes against the dataset to identify any missing aspect of

the data in the analysis. Overall, reviewing the themes ensures that they are as representative of the data as possible and answer all the research questions appropriately.

Phase 5: Defining and Naming Themes

Phase five involves defining and naming the themes to establish their role in understanding the data (Nowell et al., 2017). In other words, the researcher sets concise and easily understandable thematic names. The rationale for this phase is to formulate the meaning of each theme and understand how it contributes to the understanding of research data. In this phase, it was not only important that I refine the themes, but that I also conduct member checking to ensure the credibility of the study (Ravitch & Carl, 2021). Therefore, I emailed participants to disclose the themes of the data to participants. Participants were asked to review the themes and inform me if their perceptions did not align with the themes. No participants indicated discrepancies between the themes that were identified and their perceptions related to the research questions.

Phase 6: Producing the Report

In phase six, the research produces a report by compiling the findings and discussing their implications vis-à-vis relevant previous studies (Nowell et al., 2017). Thus, phase six data analysis allows the processing of the information to help answer the research questions and achieve the overarching purpose of this study. Reporting is an integral component of the qualitative research process because it facilitates the dissemination of findings to different audiences, including CR program-adopting organizations.

Trustworthiness

In qualitative research, trustworthiness is vital in establishing a study as a rigorous one, worthy of serious consideration (Ravitch & Carl, 2021). According to Ravitch and Carl (2021), there are 4 primary indicators of trustworthiness: credibility, dependability, confirmability, and transferability. There were several measures that were taken to ensure the trustworthiness of this study.

Credibility

In qualitative research, the credibility of a study is an indicator of how reliable a study and its findings are (Ravitch & Carl, 2021). There were several steps I took to ensure that this study is credible. One way I ensured the credibility of this study was by providing all appropriate disclosures to participants, so they had all necessary information to provide informed consent. Participants were informed of the background of the study, their rights as participants, and what they could expect about the process. Additionally, I provided participants the opportunity to review, and suggest edits to, written transcripts of their recorded interviews through a process called member checking (Creswell & Creswell, 2018).

Dependability

According to Ravitch and Carl (2021), dependability may be established though meticulous documentation of my steps and procedure taken throughout the study. For example, I provided a clear account of the steps that were taken to recruit participants, collect data, and analyze data. Following the collection and analysis of data, I solicited another researcher's assistance in reviewing the study in a process called peer review (Creswell & Creswell, 2018).

Confirmability

Confirmability refers to the objectivity of a study (Ravitch & Carl, 2021). To ensure that the study is free from undue bias and influence, I employed strategies mentioned above such as member checking and peer reviewing. By allowing the participants and a peer to review the data, I improved the trustworthiness of the qualitative study. Participants had an opportunity to confirm or refute the accuracy of the data and a peer reviewer had an opportunity to ensure that study was carried out systematically, and in a manner that others may follow (Creswell & Creswell, 2018).

Transferability

The transferability of a study refers to the extent to which a study, its procedures, and its results may be applied to other settings (Ravitch & Carl, 2021). The use of purposeful sampling will allow other researchers in similar settings and with similar populations to replicate the study (Creswell & Creswell, 2018). Further, meticulous documentation, such as the description of the data collection and analysis processes, and the alignment of the study's elements, helped ensure that the study may be easily replicated (Creswell & Creswell, 2018). In research, ethical considerations are essential to the integrity of the study and the protection of participants (Burkholder et al., 2016). Prior to conducting this study, I obtained approval from the university's IRB. The IRB reviewed the proposed study and granted approval of the proposed study because it met strict requirements and standards. No solicitation of participants or collection of data could occur prior to IRB approval.

As is the case with any qualitative study, I considered possible risks to participants. Such risks include possible identity disclosure or psychological damage (Ravitch & Carl, 2021). I disclosed all possible risks, including measures that were taken to mitigate these risks, so

participants could provide informed consent if they wished to move forward with their participation in the study. One risk mitigation strategy included the use of pseudonyms to protect the identities of participants. Further, it important to reiterate the voluntary nature of the study and to inform participants of their rights to cease participation at any time.

Lastly, it is important to note the researcher's positionality in qualitative research, and acknowledge the risk of researcher bias, especially during the data analysis process. Member checking and the use of a peer reviewer helped mitigate this potential ethical issue so that the results of this study may be taken with the utmost regard in the field.

Summary

The problem that was addressed by this study was there was a minimal understanding of how AA women perceive the influence of religiosity on their experiences in CR groups in central Georgia (Beraldo et al., 2019; Dada et al., 2018; Hosmane, 2019; Muhamad et al., 2020; Oser et al., 2019; Popovici & Simion, 2017). A qualitative phenomenological study was most aligned with the problem because this type of study provided an opportunity for in-depth inquiry into the first-hand accounts of those closest to the central phenomenon (Moustakas, 1994). The methodology described above provides an understanding of the way this study was conducted. The application of a qualitative phenomenological study design and the collection of data from semistructured interviews allowed me to explore AA women's perceptions of the influence of religiosity on their experiences in CR groups in central Georgia. Participants were purposefully selected to make certain they had first-hand experience with the problem that was studied. Like other studies, this study included specific measures designed to ensure its trustworthiness. Member checking and peer reviewing are among the strategies I used to confirm the rigor of this study and its results.

The next chapter will consist of the results of this study and will include details about the data collection process and the procedures for data analysis.

Chapter Four: Findings

Overview

This chapter presents the research findings per the four specific questions. The sections include, among other things, a thorough discussion of the findings. The setting, data collection, and analysis methods will also be discussed. Further, I will reveal the results and discuss the evidence of the trustworthiness of this study. Finally, the chapter presents the study findings, including the participants' sociodemographic characteristics. Thus, Chapter 4 provides the reader with the study outcomes and answers the research questions.

The study was conducted to understand how AA women perceive the influence of religiosity on their experiences in CR groups in central Georgia. CR programs are designed to offer unique, religion-based expertise for people seeking substance abuse treatment (Muhamad et al., 2020). In particular, AA and CR turn to a supreme power to guide them through recovery. According to research, faith-based volunteer support groups contribute over $300 billion annually in savings to the United States economy at zero cost to taxpayers (Grim & Grim, 2019). Similarly, Weinady and Grubbs (2021) contended that religious beliefs influence addiction treatment. Therefore, faith is a positive variable in recovery or addiction prevention.

The study led to a better understanding of how AA women perceive the influence of religiosity on their experience in CR groups in central Georgia, including religious elements of the program which affected their recovery journey. Research has shown that a person's faith influences their attitudes toward addiction and willingness to undergo treatment (Weinady & Grubbs, 2021). However, some studies report a negative association between religious beliefs and attitudes toward addiction. Consequently, the existing evidence needs to be more consistent and conclusive, hence the need for this study. In addition, it was essential to learn more about the

influence of religiosity on participants' experiences so that program administrators can improve the efficacy of help programs and offer resources that support recovery. Therefore, the findings provide valuable insights for designing effective CR programs that accommodate the target groups' faith.

A phenomenological qualitative study design was employed since it allowed me to engage participants in their natural settings and gain an in-depth understanding of their lived experiences. Phenomenological research is a qualitative approach to scholarly inquiry that strives to comprehend and define the universal significance of an occurrence of interest. In particular, it helps one to investigate people's everyday experiences without involving a researcher's perceptions of the subject under study. Thus, a phenomenological approach enabled me to comprehend how AA women perceive CR programs rather than focus on their existence. Furthermore, the technique allows the investigator to collect rich data that permits an authentic, unique perspective of the moderating role of religiosity on the effectiveness of CR programs in enhancing addiction recovery. However, the phenomenological research design is highly subjective, compromising its ability to establish data reliability and validity. In addition, the inherent researcher-induced bias can negatively influence the study outcomes and result in inaccurate conclusions. Moreover, interference with the data interpretation might present substantial challenges when seeking to establish and sustain pure bracketing. Therefore, the phenomenological research adopted for this inquiry provides numerous methodological advantages if its associated shortcomings are effectively addressed, allowing me to collect sufficient data for answering the research questions.

Participants

Thirteen AA women participated in this study. Their participation led to a better understanding of how AA women perceived the influence of religiosity on their experiences in CR groups in central Georgia. A summary of each participant's profile is provided below.

Anna

Anna found faith crucial in overcoming their Klonopin and Ambien addiction through the CR program, recommended by her psychiatrist. Anna appreciated the supportive 12-step process and assistance from her family and sponsor. Despite occasional urges to use, Anna has remained sober for 5 years, crediting faith in a higher being for her success.

Barbara

Barbara found strength in her belief in God and the supportive environment of the CR program. Their addiction to methamphetamine began in high school due to peer pressure. Overcoming initial trust issues and distancing herself from negative influences of certain friends, Barbara relied on faith to remain sober for 6 months and 23 days.

Cathy

Cathy enrolled in the CR program due to a friend's recommendation, after having sought support for her crack cocaine addiction that started 4 years prior. Prayer, family love, and her children's happiness motivated Cathy through the program, despite initial transportation challenges. Now 11 months sober, Cathy emphasizes that faith and belief in a higher power can make a significant difference in the success of the program.

Dorothy

Dorothy found solace in the non-judgmental environment of the CR program, which her family suggested due to her methamphetamine addiction. Dorothy's belief in God and the support of others in the program helped her overcome challenges, such as discussing her addiction and trusting others. After cutting ties with negative influences and embracing faith, Dorothy remained sober for 6 months and 23 days following the completion of the program.

Eve

Eve turned to the CR program to address her alcohol addiction, stemming from the ongoing struggle with schizophrenia. While Eve does not consider religion a significant factor in her recovery, she acknowledges the importance of faith. The support from her husband, sponsor, and psychiatrist, as well as the structured program, have been helpful in her personal journey. Facing her addiction and personal challenges was been difficult, but Eve completed the program, and emphasizes the effectiveness of the support system.

Francis

Francis, a Christian, joined the CR program on her pastor's recommendation to address her addiction to Ambien and Xanax. Francis found the support from her sponsor and family crucial in overcoming the challenges of discussing her addiction and quitting the drugs. Religion played a significant role in the recovery process, and she successfully completed the program, remaining sober for three weeks. Francis highly recommends the program to others seeking help with addiction.

Gina

Gina found the CR program very supportive in overcoming their methamphetamine addiction, which began in high school. Gina was able to talk openly about her addiction and

found faith in God crucial for their recovery. Cutting ties with naysayer friends made it easier to complete the program, and she has remained sober for over 6 months. Gina believes that faith in God is essential for overcoming challenges and achieving the impossible, such as staying sober.

Heather

Heather found the CR program challenging but beneficial in overcoming their Oxycodone addiction, which began after a surgical procedure. The faith-based aspects of the program, including prayer and the support from her sponsor, helped Heather through the difficult 12-step process. Despite wanting to give up, Heather completed the program and have remained sober for two months, attributing their success to the faith-based nature of the program.

India

India chose to participate in the CR program due to a friend's recommendation, emphasizing the program's focus on Jesus. India's experience in the program was marked by helpfulness, support, love, and compassion. Her religious background played a significant role in their recovery, as she leaned on prayer and the belief in God's love to help her overcome their addiction to methamphetamine, alcohol, and crack cocaine. India ed sober for 10 months and nine days since completing the program, attributing her success to honesty, recognizing their need for help, and relying on God and the CR program.

Janice

Janice found the CR program through prayer and a sponsor, experiencing care, support, and transformation with Jesus at the center. Challenges she faced included trusting others and self-honesty, while religion provided a solid foundation for recovery. After 18 months in the program, Janice remains sober, highlighting the Christ-centered approach as crucial for their success.

Kory

Kory, an atheist, had an unsatisfactory experience in the CR program due to feeling smothered by her sponsor and parents. Kory struggled with an Adderall addiction that began in college. The religious aspect of the program did not resonate with her, and she ultimately did not complete the program or achieve sobriety.

Lauren

Lauren had an overwhelming experience in the CR program due to struggling with a crack addiction that began in high school. She found the entire program challenging and did not feel supported. Religion did not play a helpful role in her recovery, and she ultimately quit the program after two weeks without achieving sobriety.

Marian

Marian found the CR program successful and felt supported by its members and sponsor. She struggles with marijuana addiction and are currently in her second attempt at the program. Religion plays a role in Marian’s recovery as she prays and calls her sponsor when feeling an urge to smoke. Marian believes the program's goal is to achieve sobriety through prayer and meditation, effectively replacing one addiction with another.

Results

The study's overall objective was to understand how AA women perceive the influence of religiosity on their experiences in CR groups in Central Georgia. In particular, the exploration answered four specific research questions. The first question concerned AA women's description of their experiences with the CR programs. The second regarded AA women's description of the CR programs' benefits. The third research question focused on AA women's perception of religion's role in participating in CR programs. Finally, the fourth question explored the

challenges faced by AA women participating in CR programs. Therefore, the results section presents findings based on these research questions, as indicated below.

Theme Development

Qualitative data analysis (QDA) is a sequential process that entails coding, summarizing, examining, and interpreting the collected textual data (Ravitch & Carl, 2021). The approach involves identifying recurrent themes and patterns of data, which are necessary for answering the research questions and informing recommendations for improvement. I conducted a thematic analysis of the data after transcription of interviews. Thus, the process helped me to analyze collected data to answer the research questions and make appropriate recommendations to leverage the potential of CR programs.

There were several codes that repeatedly emerged from the data during the thematic analysis process. Overwhelmingly, the participants in this study noted that the multistep process was beneficial and supported their engagement in the CR program. Specifically, participants acknowledged that the step-by-step approach to reaching sobriety made the goal feel achievable. In addition to the process, the supportive nature and design of the program was named as a factor in participants' engagement. For example, Barbara stated, "There were times when I felt I wanted to use, but because there were people to talk to who I felt were not judgmental, I told them about how I felt, and they talked me out of it." This perception of CR programs offering a supportive group environment was echoed by other participants like Janice, who recalled that her support came from her sponsor, a former participant in the CR Program. Janice stated, "I was led to attend a 12-step program. After… I met an individual that had completed the Celebrate Recovery program and became my sponsor."

Regarding the influence of religiosity on participants' experiences in CR programs, there were variances in participants' background and religious affiliations. However, most recognized a positive influence of the religious aspects of the program, such as prayer and other rituals, on their participation in the program. For example, Janice shared, " I stayed close to Jesus by reading and meditation on the word day and night…I built a new life based on God's word." India reported a similar experience when she stated, "I knew the Lord could heal me from this Demon possession addiction. I prayed and got into the word…"

Besides, *process*, *support*, and other codes, there were 4 high-level themes that emerged from the data collected from the semistructured interviews. Table 1 below displays an overview of the codes, categories, and themes that I identified during the thematic analysis process.

Table 1

Overview of Codes, Categories, and Themes

RQ1: How do AA women who have participated in CR programs describe their experiences?		
Codes	**Categories**	**Themes**
• process • supportive • accountability	• reliability	1. CR programs offer a consistent and reliable structure and a supportive environment.
RQ2: How do AA women who have participated in CR programs describe the benefits of the program?		
Codes	**Categories**	**Themes**
• process • meetings • sponsor • support • structure	• structure • group setting	2. The structured program, along with the supportive group environment, is the top benefit of CR programs.
RQ3: How do AA who have participated in CR programs describe the role of religion in participating in the program?		
Codes	**Categories**	**Themes**
• rituals • faith in recovery • prayer • process • meditation	• religious practices • faith	3. Religious practices such as prayer and meditation help participants have hope and faith in recovery.
RQ4: How do AA women describe their challenges in CR groups?		
Codes	**Categories**	**Themes**

• self-reflection • trusting others • doubt from others • sharing truthfully	• internal factors • external factors	4. A lack of trust is a barrier to openness and honesty.

As shown in Table 1 above, four fundamental themes emerged from the research data. These themes answer the four research questions and were extrapolated from data collected during the semistructured interviews. In qualitative research, the identification of themes is a critical process that involves making sense of the smallest units of data – words and phrases – and, eventually, moving toward the identification of patterns or recurring concepts (Mishra & Dey, 2022). The following themes represent the patterns or recurring concepts expressed by participants in this study.

Theme 1: CR programs offer a consistent and reliable structure and a supportive environment.

The consistent and supportive nature of CR programs were elements of CR programs that consistently emerged from the data. Participants referenced these elements of the program and seemed to fondly recall the impact of these elements. Participants often credited their sponsor, a critical component of the CR program structure, for being instrumental in helping to keep them engaged in the program and its steps.

Theme 2: The structured program and the supportive group environment are the top benefits of CR programs.

Participants in this study, regardless of their pathway to the CR program or the length of time they spent in the CR program, positively associated the structure of the program and its supportive environment with their experiences in the program. One participant, Eve, shared, “It is a very organized program, and there is a big support group. If you are religious then it may play a role, but I am not big on religion. I do have faith.” The supportive nature of the program

and its structure were also factors that contributed to participants' persistence through the program. Dorothy stated, "There were times when I felt I wanted to use, but because there were people to talk to who I felt were not judgmental, I told them about how I felt, and they talked me out of it."

Theme 3: Religious practices such as prayer and meditation help participants have hope and faith in recovery.

Participants in this study, even those with no religious affiliation, acknowledged the positive influence religious practices had on their self-efficacy, or the belief that they could complete the program. Some participants made a connection to the CR program's embedded religious practices, as they were aligned with their personal religious preferences. For example, when asked about the aspects of the program that supported her on her sobriety journey, Barbara shared:

> My faith in God. Since the program, I pray more and I am able to trust that others love me enough to help and want to see me stay sober….Yes, it takes faith in God to get through something so challenging. You must have faith to love yourself enough to want to become sober. Faith gives you the will to do anything you deem impossible.

Marian even offered a unique perspective on the religious ritual of praying and stated:

> I think the goal of the program is to get people to attain sobriety through prayer and meditation. That works well because praying can become an addiction, so in actuality we are replacing one addiction with another.

Theme 4: A lack of trust is a barrier to openness and honesty.

The final theme that emerged from the data referred to the lack of trust acting as a barrier to openness and honesty. Participants agreed that openness and honesty were required for sustainable substance abuse treatment and sobriety. However, they noted that being in denial and feelings of shame prevented them from being open and honest with others. Janice described a barrier as her unwillingness to "develop trust to share my innermost feelings with strangers and be honest with myself." India shared a similar sentiment when she described a difficulty, stating, "It was hard trusting and sharing my battle with addiction with others and listening while others share theirs…" Similarly, Gina stated, "It was challenging just talking about my addiction at first and trusting others."

Research Question Responses

The study's overall objective was to understand how AA women perceive the influence of religiosity on their experiences in CR groups in Central Georgia. In particular, the exploration answered four specific research questions. The first question concerned AA women's description of their experiences with the CR programs. The second regarded AA women's description of the CR programs' benefits. The third research question focused on AA women's perception of religion's role in participating in CR programs. Finally, the fourth question explored the challenges faced by AA women participating in CR programs.

The AA women asserted that CR is a great program, but the lack of trust hinders participants from being vulnerable and honest about their alcoholism or other drug use. Trust is crucial for CR participants to disclose their lived experiences to inform the design of more responsive recovery initiatives. Additionally, being able to trust the CR process motivated participants to commit to the process. CR provides a Christ-centered twelve-step method

anchored on the Beatitudes to help patients surmount their painful experiences with addiction. The robust program strives to unite the addicts and their churches to discover new approaches to care, acceptance, and grace. Thus, trust is critical for realizing the program's goal. Consequently, the challenge often forces some addicts to abandon recovery.

Table 2 below shows the research questions, the themes or results, and sample excerpts from the participants' transcripts.

Table 2

Themes and Sample Excerpts

RQ	Theme/Results	Sample Excerpts
RQ1: How do AA women who have participated in CR programs describe their experiences?	1. Participants in CR programs appreciate the consistency and reliability of the structure.	*It is a very organized program and an extensive support group* (P5).
RQ2: How do AA women who have participated in CR programs describe the benefits of the program?	2. The structured program, along with the supportive group environment, is the top benefit of CR programs.	*The program aims to get people to attain sobriety through prayer and meditation. That works well because praying can become an addiction, so we are replacing one habit with another* (P13).
RQ3: How do AA who have participated in CR programs describe the role of religion in participating in the program?	3. Religious practices such as prayer and meditation help participants have hope and faith in recovery.	*We were encouraged to pray a lot, which helped more than anything. It brought me closer to God. I did much crying, but at the same time, I was slowly letting off the crack* (P3).
RQ4: How do AA women describe their challenges in CR groups?	4. A lack of trust is a barrier to openness and honesty.	*It was hard to trust and share my addiction with others and listen while others shared theirs (P9).*

Summary

The AA women who participated in this study reported having rewarding experiences with the CR programs. Such encounters were attributed to the program's consistent, reliable structure and supportive environment. Additionally, the AA women noted that the CR programs are associated with religious practices, such as prayer and meditation, helping people who suffer from addiction to have hope and faith in recovery. Participants who have participated in the CR program shared it is a beneficial, structured model that offers significant support. However, participants also noted that the lack of trust impedes its potential by inhibiting participants' openness and honesty. Thus, the findings suggest that, despite CR's significance as a practical recovery model, its ability is limited by participants' lack of trust in the process, which impedes openness and honesty in CR groups.

Chapter Five: Conclusion

Overview

The purpose of this qualitative phenomenological study was to explore AA women's perceptions of the influence of religiosity on their experiences in CR groups in central Georgia. In chapter 5, I will conclude this dissertation with a final discussion of the findings. Also included in this chapter is a discussion of the methodological and practical implications of this study, a description of the delimitations and limitations, and, finally, recommendations for future research.

Summary of Findings

The findings from this study were derived from a thorough analysis of the data collected from semistructured interviews. One key finding of this study was that CR programs offer structure and support. Another key finding was that the structure and support offered by CR programs were beneficial to AA women. A third key finding was that the religious elements of CR programs supported self-efficacy in participants. A more detailed discussion of these findings is below.

Discussion

Key Finding 1

The study established that the CR programs offer participants a consistent and reliable structure and a supportive environment. CR programs are faith-based substance abuse recovery programs that follow a 12-step philosophy to motivate participants to account for their experiences and grow. Turner (2018) observed that CR's consistent and reliable structure helps enhance participants' confidence, enabling them to resist substance abuse. Additionally, the programs empower people addicted to drugs to develop the necessary strategies for improving

their mental health and well-being (Turner, 2018). According to Best and Colman (2018), the recovery process is a dynamic phenomenon that occurs over time. In addition, it is a function of a changing interaction between internal and external factors. Therefore, given the nature of the substance abuse recovery process, a structured, contextual, and supportive recovery pathway like the CR model offers a practical approach to fostering meaningful participation and successful recovery from illicit alcohol and drug use.

Key Finding 2

The CR programs are structured beneficial recovery models with a supportive group environment. Research has shown that faith-based interventions, such as CR programs, are helpful in several ways. For example, Mjolsness's (2019) phenomenological study explored participants' experiences in a Christian-based recovery intervention. The results indicated that the CR programs provide structure and support, making recovery possible for people struggling with drug addiction. The CR encourages participants not to let their past ruin their future, motivating them to rely on Christ when making progressive decisions. In addition, the program motivates drug addicts and alcoholics not to dwell in self-blame and condemn others. Therefore, the research finding affirms that CR programs structured and supportive group environments make them practical recovery paths for participants.

Key Finding 3

Although CR programs' religious practices, such as prayer and meditation, help participants to be hopeful and faithful in the recovery process, a lack of trust can impede participants' openness and honesty. Acceptance and acknowledgement of the weight of addiction and the need to rely on God are integral components of the CR model. The participants must have confidence in the CR process and be willing to disclose their lived experiences to inform

the design of more responsive recovery initiatives. Moreover, the assurance inspires illicit substance users and alcoholics to commit to the process. Further, the effective program strives to unite the addicts and their churches to discover new approaches to care, acceptance, and grace. Thus, trust is critical for realizing the program's goal. Consequently, a lack of trust often forces some people who suffer with addiction to abandon recovery.

Implications

The research findings provide valuable insights for designing and implementing effective CR programs that motivate alcoholics and drug addicts to commit to and complete the recovery process. The programs' consistent and reliable structures make them rewarding for the target beneficiaries. Additionally, the CR initiatives provide a supportive environment for the participants to recover successfully. However, program managers must address the potential trust issues in CR to leverage their potential as effective recovery models. Consequently, CR programs are significant recovery pathways whose benefits can be maximized by addressing the underpinning trust problems.

Positive Social Change at the Organizational Level

The research findings help influence positive social change at the organizational level. For instance, CR programs help create a consistent, reliable environment where people suffering from addiction feel supported and valued. In addition, the initiatives help participants become hopeful and have faith in the recovery process. Additionally, the research findings demonstrate the significance of religiosity in determining the effectiveness of CR programs as functional recovery pathways. However, organizations must address the challenge of trust inherent in these models to leverage their potential. Overall, the CR programs enable recovery centers to create

structured, consistent, reliant, and supportive environments for their clients to improve their mental health and well-being.

Methodological Implications

The study corroborates the potential of a qualitative research approach to help investigators understand participants' lived experiences with CR programs. The qualitative research methodology used in this study led to the collection of data related to the first-hand experiences of participants close to the central phenomenon. The semi-structured interviews provided the structure for open-ended exploration into participants' lived experiences with CR programs. Quantitative methodologies would not have been suitable for this study. Additionally, the research confirms the reliability of Zoom for virtual interviews in qualitative research. The study also corroborates the practicability of the thematic analysis approach in examining the qualitative data to answer the research questions. Finally, the methodological rigor makes the research findings reliable and applicable in other organizational contexts with similar variables.

Theoretical Implications

The research findings contribute to the existing theoretical postulations regarding the potential of CR programs as an addiction prevention and recovery model. For instance, the results corroborate the notion that religion influences individuals' attitudes toward the addiction recovery process. Additionally, a person's faith plays a determinant role in their attitude towards the choice of treatment. The findings also confirm the potential of CR programs as effective recovery pathways. Therefore, CR program designers should consider the religious beliefs of target beneficiaries to maximize the intended benefits.

Delimitations and Limitations

There are delimitations (decisions I made to bound the study) and limitations (potential weaknesses) of this qualitative study (Ravitch & Carl, 2021). One of the delimitations of this study was my intentional use of a phenomenological study design. I chose this design to align with the study's central phenomenon and purpose. This design supported my study a central phenomenon from participants who are close to it and have first-hand experience (Moustakas, 1994). Another delimitation was my eligibility criteria, which included only women who were at least 18 years of age. I chose this delimitation to minimize potential harm and other ethical barriers when working with minors.

The study was limited to AA women who have participated in CR programs. Specifically, the eligibility criteria served as limitations of this study. The eligibility criteria included: AA women who (a) were aged between 18 and 30 years old; (b) have experienced drug and substance addiction; and (c) have participated in a CR program. Additionally, the research only considered CR groups in central Georgia. Further, the methodology was another limitation of this study. Another limitation of this study was the member checking process. Member checking was done to ensure that participants could confirm the accuracy of the data. Even though the research method adopted for this investigation helped develop an in-depth understanding of the participants' lived experiences with the CR programs, it was challenging to investigate causality with the approach. Therefore, these limitations potentially have a bearing on the results of this study and their universal applicability.

Recommendations for Future Research

Addressing the limitations of this study is necessary. For instance, CR program designers and managers should address the underpinning issue of trust to enhance participants' openness

and honesty. In addition, there is a need for future studies on this subject matter to consider participants in CR programs with experiences in other forms of recovery paths, such as NA and cocaine anonymous (CA). Moreover, future researchers should also consider AA men who have participated in CR programs to determine the mediating or moderating influences of gender on participants' perceptions of CR programs. Further, I would recommend that future research is conducted using only participants who have completed CR programs and have been sober for at least 6 months. This might help ensure that all participants have experienced all elements of the program. Finally, the present study adopted a qualitative research approach, which allows the investigator to gain an in-depth understanding of the subjects' lived experiences. However, the research design has several limitations, including its inability to determine the causal-effect relationships between research variables. Therefore, there is a need for future inquiries to consider a mixed-methods design approach to leverage the benefits of qualitative and qualitative research methods.

Summary

AA women who have participated in the CR program think that although it is a beneficial structured model with a supportive model, the lack of trust impedes its potential by hindering participants' openness and honesty. Nonetheless, the research findings indicate that the celebrate recovery model provides a consistent and reliable structure for keeping successful recoveries from illicit drug and alcohol use. Therefore, organizations adopting CR programs should consider participants' religious beliefs and strive to increase their confidence in the recovery pathways.

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APPENDIX A: Interview Protocol

Interview Protocol

Title of Study: RELIGIOSITY IN DRUG USE AND ADDICTION AMONG AFRICAN AMERICAN WOMEN: A QUALITATIVE PHENOMENOLOGICAL STUDY

Date:

Location:

Time of Interview:

Interviewer: Felice Saleem

Interviewee:

Greeting:

"Hi and thank you so much for being here today. My name is Felice Saleem, and I am a doctoral student at Liberty University. I really appreciate you agreeing to participate in this study. I hope you find this process rewarding as your participation will help add to a gap in current research. I have selected you to participate in this study because you have participated in a Celebrate Recovery program in central Georgia. I have received your *Informed Consent* form; however, I want to be sure that I, again, have your consent to proceed with this interview. Please remember that you may withdraw consent at any time during the process and I will, immediately, destroy all your information and properly discard it. I want to remind you that all efforts will be made to maintain confidentiality and your name, the program's name, and all personal information will remain private. Do you have any questions for me about the study, including the process, or any of the information provided on the *Informed Consent* form?"

Checklist:

____Participant submitted signed *Informed Consent* form. (Have additional copies to review, if needed)

____Participant is interested in moving forward with study participation. (If not, stop here, thank participant, and follow procedures to destroy participant information.)

Interview Norms:

- Speak from the *I* perspective.
- Please refrain from disclosing others' personal information, including their names and roles at the program.
- Please ask for clarification if a question does not make sense to you.
- Please remember you may cease participation in this study at any time.

"Do you have any questions before we proceed? Do you wish to proceed?"

Background/Purpose:

"This interview is designed to help me gain a better understanding of your perceptions about the influence of religiosity on your experiences in Celebrate Recovery groups in central Georgia. I encourage you to share freely, providing as many details as you can. I will be taking notes and this interview will be recorded so I don't miss anything. You will notice that I will be looking at you and looking down at my notes, but please know I am paying attention and appreciate what you have to say. I will also be reading questions I prepared ahead of time. However, I might also ask follow-up questions if I need you to clarify a point or want more information."

"Do you have any questions? Do I have your permission to proceed with this interview and recording?"

Questions:

3. How old are you now and how old were you when you began the CR program?
4. How long did you participate in the CR program?
5. What does it mean to be religious to you?
6. What made you choose to participate in the Celebrate Recovery program you selected?
7. Describe your overall experience in the Celebrate Recovery program.
8. Describe the aspects of the program that made you feel supported.
9. What drugs were you/are you addicted to and how did the addiction begin?
10. Describe aspects of the program you found challenging.
11. Tell me about any part religion might have played in your recovery and how it affected you
12. What made it easier for you to complete the program?
13. What made it more difficult for you to complete the program?
14. How long did you remain sober after completing the program?
15. Are there any final thoughts you would like to share about your experience in the Celebrate Recovery program, and the role of religion in your participation in the program and recovery?

Closing:

"Thank you so much, again, for your time today. I appreciate you participating in this study and providing me with you open and honest feedback. I want to remind you that your responses will be kept confidential, and you may still withdraw participation at any time. I will follow up with you within a week to review my notes and transcription so you may review them for accuracy.

Do I have your permission to contact you for a follow-up/debrief call? Thank you and have a wonderful day!”